

Appendix 13

Example of a Prior Authorization Request Form (PA/RF) for Personal Care-Only Services by One Provider

MAIL TO:

E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF

(DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE

121

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER 1234567890				4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE) 609 Willow Anytown, WI 55555			
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) Recipient, Im A.				8 BILLING PROVIDER TELEPHONE NUMBER (XXX) XXX-XXXX			
5 DATE OF BIRTH DD/MM/YY		6 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		9 BILLING PROVIDER NO. 87654321			
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I. M. Provider 10 W. Williams Anytown, WI 55555				10 DX: PRIMARY 429.2 - CVA			
				11 DX: SECONDARY 250.0 - diabetes II (NIDDM)			
				12 START DATE OF SOI: N/A		13 FIRST DATE RX: MM/DD/YY	

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W9900 (or W9903)		4	1	PCW	728	XXX.XX
				14 hr/wk x 52 wk		
W9902		4	1	3.5 hr/wk TT X 52 wk	182	XXX.XX
					21 TOTAL CHARGE	XXXX.XX

22. An approved authorization does not guarantee payment.

Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

start: MM/DD/YY

23 MM/DD/YY
DATE

24 J M Provider RN
REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐
APPROVED

☐
MODIFIED

☐
DENIED

☐
RETURN

REASON:

REASON:

REASON:

GRANT DATE

EXPIRATION DATE

PROCEDURE(S) AUTHORIZED

QUANTITY AUTHORIZED

*** Regardless of the amount entered in element 19, the quantity you are authorized to provide is indicated here by the Medicaid professional